S. No. 300
v. 10-48

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No. 6488

BIRTH NO. ____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1204

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St Clair 499
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis c. LENGTH OF STAY (in this place)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) East St Louis 1/0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Peoples Hospital	d. STREET ADDRESS (If rural, give location) 2412 Gaty Ave
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Almeta M Morris	4. DATE OF DEATH (Month) (Day) (Year) 2-4-49
5. SEX F 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 7-27-1895 9. AGE (In years last birthday) 53 If under 1 year: Months 6 Days 24 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY House work	11. BIRTHPLACE (State or foreign country) Cleveland Ohio 12. CITIZEN OF WHAT COUNTRY? America
13a. FATHER'S NAME A M Morris 13b. MOTHER'S MAIDEN NAME Margrett Dawson	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Stella Stevenson ADDRESS E St Louis Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis Chronic	1 yr
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b) Hypertension	?
	DUE TO (c)	592X
	II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Early Gangrene Rt lower leg	2 wks
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* Feb 1, 1949, *to* Feb 4, 1949, *that I last saw the deceased alive on* Feb 3, 1949, *and that death occurred at* 3:40 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. Jackson (Degree or title) M.D.	23b. ADDRESS Wood Bldg, E St Louis, Ill		23c. DATE SIGNED 2/7/49
24a. BURIAL, CREMATION, REMOVAL (Specify) E St Louis Ill	24b. DATE 2-7-49	24c. NAME OF CEMETERY OR CREMATORY Booker Washington	24d. LOCATION (City, town, or county) (State) Centreville Station Ill
DATE REC'D BY LOCAL REG. FEB 8 1949	REGISTRAR'S SIGNATURE J. B. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Officer	ADDRESS E St Louis Ill

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

_____ Student Embalmer No. _____,

working under my personal supervision.

Signed W. E. Offutt

Signed _____
Student Embalmer

Licensed Embalmer No. 3578

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.